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PERSONAL DATA: The following information will be used to facilitate your therapy. As with other information you supply, it is protected by the rules of confidentiality. Please fill out the blanks as fully and as accurately as you can.

Date _____ Name _____ DOB_____

Maiden/Other Names:_____ Gender (circle): M F Social Security #_____

Address _____

Mailing address (if different from above) _____

Phone #'s: Home_____ Work_____ Mobile_____

E-mail _____

Emergency contact _____ Ph.# _____ Relationship _____

Primary care physician _____ Phone # _____

Who referred you to me?_____

What insurance coverage do you have?_____

Current marital status: ___Single ___Married ___ Remarried ___Separated ___Divorced ___Widowed

With whom do you live? (names & relationships)_____

_____

Cultural Identity_____ Sexual orientation (optional): _____

Current employment status __full-time __part-time ___Homemaker full-time __Unemployed(since_____)
___Not in labor force (e.g., student) ____Disabled (why?_____)

Employer:_____

Occupation_____ Highest year of education completed_____

Do you have any learning disabilities? If yes, please describe_____

Do you have any pending legal charges or involvement? If yes, please specify:_____

Are there any firearms in the home where the child may reside? ___No ___Yes (If yes, please explain how these firearms are stored) _____

Have you ever been involved with Social Services ____Yes ____ No
If Yes, when & why? _____ _____

Present issues for which you seek treatment_____

_____

Give a brief history of your issues (from onset to current)

_____
_____

_____

How would you like your situation to be different as a result of treatment?_____

_____

How strongly do you want treatment? ___very much ___much ___moderately ___not much ___not at all

Please check any of the following that currently apply to you:

__Nightmares	__Difficulty with anger	__Feel shut down/numb	__See things others don't see
__Tense	__Unable to make friends	__Feel shame frequently	__Worry about sexual matters
__Panicky	__Unable to have fun	__Tension at home	__Take risks excessively
__Lonely	__Frequently feel guilty	__Can't make decisions	__Forgetful/spacey
__Moody	__Suicidal thoughts	__Homicidal thoughts	__Need others too much
__	__Job dissatisfaction	__Financial problems	__Work too much

__Unable to find or keep a job __Feel others are trying to control my mind
__Hear voices others don't hear __Others think there is something wrong with my mind

Mental Health Treatment History (List who provided, when, and for what issues)

	Who/Where	Dates	Issues
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Have you had any hospitalizations for psychological problems? If yes, please describe_____

_____

Have you ever made a suicide attempt? If yes, please elaborate when, how, and why_____

_____

Has anyone in your family had psychological or substance abuse problems? If yes, please describe_____

_____

Have any relatives committed suicide? If yes, when, how, and why?_____

_____

Medical History

Please list any current medical problems_____
_____

(For women only): Pregnant now? __Yes __No __Unsure (If yes, due date:_____)

Please check if any of the following symptoms currently apply to you:

__Weight loss	__Poor appetite	__Difficulty sleeping	__Fast heartbeat
__Weight gain	__Ankle swelling	__Headaches	__Sleeping too much
__Constipation	__Urinary problems	__Dizziness	__Tingling in hands or feet
__Fainting spells	__Deafness	__Weakness	__Nausea or vomiting
__Dry skin	__Big appetite	__Blurred vision	__Shortness of breath
__Hair loss	__Ringing in ears	__Chest pain	__Problems with sexual organs
__Diarrhea	__Indigestion	__Menstrual problems	
__Chronic pain	__Tremors	__Fatigue	

Please list all medications you currently use, both prescribed and non-prescribed:

Name of medication	Dosage	Prescribed by
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any current or history of addictions to prescribed medications? If yes, when and to which medications
_____

Have you had any hospitalizations for medical reasons? If yes, please describe_____

_____

Please mark if you or any blood relatives have had any of the following (Mark **Y** for you and **R** for relative):

__Cancer	__Miscarriage	__Allergies	__Heart trouble
__Thyroid problem	__High blood pressure	__Diabetes	__Neurological disease
__Kidney trouble	__Epilepsy/seizures	__HIV positive	__Other hormonal illness
__Eye trouble	__Abortion	__Head injury	

Alcohol and Drug History

In the last year, have you ever drunk or used drugs more than you meant to? __Yes __No

Have you felt you wanted or needed to cut down on your drinking or drug use in the last year? __Yes __No

Any drug or alcohol related arrests? __No __Yes Ever had D.T.'s (delirium tremens)? __No __Yes

Any blackouts from drugs or alcohol? __No __Yes Ever injected drugs? __No __Yes

How many cigarettes, if any, do you smoke in a day?_____

How much coffee or drinks with caffeine do you drink in a day?_____

Please check which of the following substances you have used:

	When began use?	Used in the past year?	How often?
Alcohol	_____	_____	_____
Inhalants/Glue	_____	_____	_____
Marijuana/Hashish	_____	_____	_____
Amphetamines/Speed	_____	_____	_____
Barbituates/Downers	_____	_____	_____
Valium, Xanax, etc.	_____	_____	_____
Psychedelics/LSD,etc.	_____	_____	_____
Cocaine/Crack	_____	_____	_____
Heroin/Opiates	_____	_____	_____
Other_____	_____	_____	_____

Religious/Spiritual:

What was your religious upbringing?_____

What do you currently practice?_____

Trauma history: (Check any that apply and elaborate below)

__Minor/major car accidents
__Natural disasters
__Abandonment
__Emotional abuse
__Physical abuse
__Loss of a loved one
__War trauma
__Invasive medical/dental procedures
__Illnesses involving high fever
__Prolonged immobilization, e.g, casting
__Exposure to extreme heat or cold
__Sexual abuse
__Catastrophic injury
__Witnessing domestic violence
__Falls
__Accidental poisoning
__Difficult birth
__Rape or assault
__Parental divorce
__Other_____

Is there anything else you would like to tell me?